# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10768 — Reg. Dist. No. 10770 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 636 Dover St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AVERY — Middle CARLTON — Last ADKINS

4. DATE OF DEATH: Month OCT. — Day 10 th — Year 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 28,1909

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee - Laborer (Swanson & Campbell Co.)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): R.D.# 3 Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unk

14. MOTHER'S MAIDEN NAME: Annie M. Adkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Lillian P. Adkins (Wife) Address: 636 Dover St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): chronic cor pulmonale.
DUE TO
(c):

434.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-11, 1954, to 10-10, 1956, that I last saw the deceased alive on 10-10, 1956, and that death occurred at 3:30 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A C Mitchell M.D.
ADDRESS (Street, city or town, state): 211 Maryland Ave. (Office) Salisbury, Maryland
DATE SIGNED: Oct. 12 1956

PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct.13,1956
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: OCT 15 1956

24b. REGISTRAR'S SIGNATURE: Mary T Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG206 11-2-56 et

10771

# CERTIFICATE OF DEATH

10769

Reg. Dist. No. 332

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place) 6 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS (If not in hospital or institution, give street address or location) Peninsula General

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland COUNTY Worcester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City

STREET ADDRESS (If rural give location) 23rd-2

**3. NAME OF DECEASED** (Type or Print) (First) Clarence (Middle) E (Last) Adkins

**4. DATE OF DEATH** (Month) 10 (Day) 24 (Year) 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 24 HRS. Hours | IF UNDER 24 HRS. Min. |
|---|---|---|---|---|---|---|---|---|
| M | White | Widowed | Feb. 10 1879 | 77 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| WATERMAN | | VA. | U.S.A. |

13. FATHER'S NAME John Adkins

14. MOTHER'S MAIDEN NAME Ellen Baker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|
| | | Wm. Adkins, Ocean City, Md |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 week

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 10/19/, 1956, to 10/25/, 1956, that I last saw the deceased alive on ....., 19....., and that death occurred at .....M, from the causes and on the date stated above.

| SIGNATURE | ADDRESS (Street, city, town, state) | DATE SIGNED |
|---|---|---|
| Wilbur R. Ellis M.D. | Salisbury, Md. | 10-25-56 |

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-27-56 | Greenbackville | Greenbackville VA |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| 10/29/56 | Mary W. Holloway | Mrs. N. A. Shields | New Church |

M White

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1077 — 13034 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 8 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: New York — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BRONX, N. Y.
d. STREET ADDRESS: 517 LINTON Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: — Last: Ahern

4. DATE OF DEATH: Month: 10 — Day: 7 — Year: 1956

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 11-5-37 — 9. AGE (In years last birthday): 19 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jaes AHERN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES ✓ (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: U.S. NAVY Records, WASH., D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

825 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebral Hemorrhage — 8 hrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.): Auto Accident
20c. TIME OF INJURY: Hour — a. m. / p. m.: 12:15 — Month, Day, Year: 10-7-56
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer — M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 10-7-56

EXAMINER'S NAME (Type): Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 10-7-56
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Portsmouth, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Ed Matthews — ADDRESS: Derry-Twiford Funeral Home, Norfolk, Va.
24a. REC'D BY REGISTRAR — DATE: DEC 13 1956
24b. REGISTRAR'S SIGNATURE: Mary H Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10772

Reg. Dist. No. 337

10771

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen. Gen. Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Penna. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia.
d. STREET ADDRESS: Ontario Street, 1905
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sidney — Middle: P. — Last: Anderton

4. DATE OF DEATH: Month: Oct. — Day: 22. — Year: 19 56.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐: Single

8. DATE OF BIRTH: Nov. 22. 1909

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months: 11 — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Supervisor
10b. KIND OF BUSINESS OR INDUSTRY: Westing House Elect. Co.
11. BIRTHPLACE (State or foreign country): Providence, R.I.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sidney A. Anderton
14. MOTHER'S MAIDEN NAME: Clara G. Pollard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War # 2
16. SOCIAL SECURITY NO.: 166_07_0751
17. INFORMANT — Address: Mrs. Dorothy Anderton Brown (Sister) 1905 Ontario, St. Phila. 34. Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I taak charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-23-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 26. 56.
22c. NAME OF CEMETERY OR CREMATORY: Providence Cemetery.
22d. LOCATION (City, town, or county) (State): Providence, R.I.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Holloway & Co. Salisbury, Maryland.
24a. REC'D BY REGISTRAR. DATE: OCT 24 1956
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10773

10772

# CERTIFICATE OF DEATH

Item 3 Film G295 10/22/56 ge.

Reg. Dist. No. 332

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY

LENGTH OF STAY (In this place) 6½ hours.

HOSPITAL OR INSTITUTION OR STREET ADDRESS PENINSULA GENERAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE VIRGINIA COUNTY ACCOMACK

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ONANCOCK

STREET ADDRESS (If rural give location) 8 KERR ST.

**3. NAME OF DECEASED** (Type or Print) (First) WILLIAM (Middle) E. (Last) BELL

**4. DATE OF DEATH** (Month) OCTOBER (Day) 3 (Year) 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | | 4-24-1876 | 80 yrs. | 5 | 9 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Seafood Retailer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Robert J. Bell

14. MOTHER'S MAIDEN NAME Susan Savage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS Dorothy Lawrence - Smithland Va.

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Myocardial Infarct, acute — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

**22. I hereby certify** that I attended the deceased from ..... 19..... to ..... 19..... that I last saw the deceased alive on 10-3, 1956, and that death occurred at 10 P.M. from the causes and on the date stated above.

SIGNATURE William R. Ellis, Jr. M.D. ADDRESS (Street, city, town, state) Salisbury, Md. DATE SIGNED 10-3-56

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-6-56 | ONANCOCK | ONANCOCK, Va. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| 10-6-56 | Mary W. Holloway | Merlin A. Williams |

RECEIVED
OCT 9 1956
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10774

Reg. Dist. No. 332

10773

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 520 Tangier St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Noah — Middle: — Last: Boone

4. DATE OF DEATH: Month: 10— Day: 7 Year: 1956

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 5, 1938

9. AGE (In years last birthday): 28 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Va

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 230-22-0433

17. INFORMANT: Blanch Drake — Address:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bullet wound of the aorta — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
981X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot by brother during a quarrel.

20c. TIME OF INJURY: Hour: 1 P a. m. p. m. — Month, Day, Year: 10 7 1956

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Salisbury (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-15-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 17-1956
22c. NAME OF CEMETERY OR CREMATORY: Green Hill Cem
22d. LOCATION (City, town, or county): Salisbury (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Booker M. West — ADDRESS: Salisbury Md

24a. REC'D BY REGISTRAR DATE: 10-16-56

24b. REGISTRAR'S SIGNATURE: Mary M. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10775

10804

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden
c. LENGTH OF STAY IN 1b: 24 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.F.D. #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden
d. STREET ADDRESS: R F D #2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Anne — Last: Bounds

4. DATE OF DEATH: Month: ~~11~~ 10 — Day: 31 — Year: 19 56

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: April 28, 1913 — 9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafeteria — 10b. KIND OF BUSINESS OR INDUSTRY: Lunch room — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George William Bounds

14. MOTHER'S MAIDEN NAME: Belle Taylor (Mrs. George William Bounds)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 215-36-0548

17. INFORMANT — Address: Mother-Mrs. George Bounds — Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carbon monoxide poisoning — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hose connected to exhaust pipe.

20c. TIME OF INJURY: Hour: 12 Noon a. m. p. m. — Month, Day, Year: 10-31-56 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☒ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Woods — 20f. (City or town): Eden — (County): Wicomico — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 11-2-56

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11/3/1956 — 22c. NAME OF CEMETERY OR CREMATORY: Sharon Cemetery — 22d. LOCATION (City, town, or county): Salisbury — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George C. Hill II — ADDRESS: Salisbury, Md. — 24a. REC'D BY REGISTRAR — DATE: NOV 7 1956 — 24b. REGISTRAR'S SIGNATURE: Mary H. Calloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10805 **CERTIFICATE OF DEATH** 10776

Reg. Dist. No. 320

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanticoke
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanticoke
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bradford; Middle:; Last: Bradshaw

4. DATE OF DEATH: Month: Oct. Day: 22 Year: 1956

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/1/1889

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months: 11 Days: 21
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fisherman

10b. KIND OF BUSINESS OR INDUSTRY: Commerical

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William H. Bradshaw

14. MOTHER'S MAIDEN NAME: Amelia Elzey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 213-24-2493

17. INFORMANT: Address: William Bradshaw, Nanticoke, Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 days

331X

DUE TO (b): Generalized Arterio sclerosis — 10 Years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 May, 1947 to 22 Oct., 1956, that I last saw the deceased alive on 22 Oct., 1956, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H Saunders M.D. — ADDRESS (Street, city or town, state): Nanticoke Md — DATE SIGNED: 10/23/56

PHYSICIAN'S NAME (Type): Richard H. Saunders — Nanticoke, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/24/56

22c. NAME OF CEMETERY OR CREMATORY: Nanticoke Cem.

22d. LOCATION (City, town, or county) (State): Nanticoke, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. D. Messick — ADDRESS: Bivalve, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 29 1956

24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10777

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

10774

Reg. Dist. No. 33-r

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (In this place) 2 WEEKS

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE MARYLAND COUNTY SOMERSET

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POCOMOKE

STREET ADDRESS (If rural give location) RURAL #1

19x-2

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Leonard | W. | Brittingham | October | 16 | 1956 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | MARRIED | Nov 17, 1903 | 52 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| FARMER | Poultry | Sallie Beauchamp | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Bert Brittingham | Maryland |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| No | — | 220-01-8875 | Mrs Lillian B. Brittingham Rt 1 Pocomoke |

**18. MEDICAL CERTIFICATION**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| 416X IMMEDIATE CAUSE (A) | Bacterial Endocarditis | 1 week |
| ANTECEDENT CAUSE(S) DUE TO (B) | Rheumatic Heart Disease | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 9/27/, 1956, to 10/16/, 1956, that I last saw the deceased alive on ....., 19....., and that death occurred at .....M, from the causes and on the date stated above.

SIGNATURE Raymond T. Gilmore M.D. ADDRESS (Street, city, town, state) Salisbury, Md. DATE SIGNED Oct. 16, 1956

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | OCT 18, 1956 | BAPTIST CEMETERY | POCOMOKE, MD. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| OCT 19 1956 | Mary N. Holloway | Henry H. Watson Pocomoke, Md. |

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10778

10775

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 337

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

LENGTH OF STAY (in this place) 70 yr

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Delaware COUNTY Sussex.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Seaford #R.R 3. Box-3

STREET ADDRESS (If rural give location)

**3. NAME OF DECEASED** (Type or Print) (First) Spencer (Middle) (Last) Calloway

**4. DATE OF DEATH** (Month) October (Day) 4th (Year) 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 9-28-1886 | 70 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Farm | Maryland | U.S.A. |

13. FATHER'S NAME Charles Calloway

14. MOTHER'S MAIDEN NAME Hetsel Ige Williams

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no) or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|
| No | 216-14-2552 | Amelia Calloway - Seaford RZ 1043 |

**18. MEDICAL CERTIFICATION**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| IMMEDIATE CAUSE | (A) Rupture of pulmonary artery into bronchus | 15 minutes |
| ANTECEDENT CAUSE(S) | DUE TO (B) Lung Abscess | 3-6 mos. |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | DUE TO (C) Bronchogenic Carcinoma | >6 mos |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 6/3, 1956, to 6/4, 1956, that I last saw the deceased alive on 6/4, 1956, and that death occurred at 1.65P.M, from the causes and on the date stated above.

**SIGNATURE** Edward Lardner Jr. M.D. — **ADDRESS** (Street, city, town, state) 325 S. Dual St. Salisbury Md — **DATE SIGNED** 10/4/56

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-7-56 | Galestown | Galestown, Md |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| OCT 11 1956 | Mary N. Holloway | Charles W. Mann | Shaptown Md |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10776 10779

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reids Grove
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: — Last: Camper

4. DATE OF DEATH: Month: October — Day: 19 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1889

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: No data

14. MOTHER'S MAIDEN NAME: Mary Ida Stanley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address:

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Uremia, Chronic | ? |
| DUE TO | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | Glomerulonephritis, chronic | ? |
| DUE TO (c) | | |

592X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 27, 1956, to Oct. 19, 1956, that I last saw the deceased alive on Oct. 18, 1956, and that death occurred at 6 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. V Juerman. M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 10/19/56

PHYSICIAN'S NAME (Type): V. Juerman, M. D.
Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 23, 1956
22c. NAME OF CEMETERY OR CREMATORY: Reid's Grove Cemetery
22d. LOCATION (City, town, or county) (State): Reid's Grove, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J.J.Frampton and Son, Federalsburg, Maryland

24a. REC'D BY REGISTRAR — DATE: 10/24/56

24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10780 337

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

10777

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 yr. 11 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton
d. STREET ADDRESS: High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arlie — Middle: - — Last: Collison

4. DATE OF DEATH: Month: October — Day: 12, — Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 28, 1877

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Collison

14. MOTHER'S MAIDEN NAME: --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 220-0909851

17. INFORMANT: Hospital Records — Address: Salisbury, Maryland

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism (recurrent) — INTERVAL BETWEEN ONSET AND DEATH: (Recurrent)
465 X
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of the left femur
9049

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 4, 19 54, to October 12, 19 56, that I last saw the deceased alive on October 12, 19 56, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L.V. Maldve M.D.
ADDRESS (Street, city or town, state): Salisbury, Maryland
DATE SIGNED: 10/12/56
PHYSICIAN'S NAME (Type): L.V. Maldve
Deer's Head State Hospital
L.V. Maldve, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 17
22c. NAME OF CEMETERY OR CREMATORY: Denton
22d. LOCATION (City, town, or county) (State): Denton Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. V. Moore & Son
ADDRESS: Denton Md

24. REC'D BY REGISTRAR DATE: 10/19/56
24b. REGISTRAR'S SIGNATURE: Mary M. Hollowa[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10781

10806

## CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jesterville
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jesterville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: C. — Last: Conway

4. DATE OF DEATH: Month: Oct. — Day: 12 — Year: 19 56

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 11/6/1874

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months: 11 — Days: 24
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Conway

14. MOTHER'S MAIDEN NAME: Esther ------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: ------

17. INFORMANT: George Conway, Jesterville, Maryland
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO (b): Cerebral Arteriosclerosis. — 5 years.
DUE TO (c):

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 June, 1948, to 12 Oct., 1956, that I last saw the deceased alive on 12 Oct., 1956, and that death occurred at 10 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H. Saunders M.D.
ADDRESS (Street, city or town, state): Nanticoke Md.
DATE SIGNED: 10/17/56

PHYSICIAN'S NAME (Type): Richard H. Saunders
Nanticoke, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/15/56
22c. NAME OF CEMETERY OR CREMATORY: Jsterville Cem.
22d. LOCATION (City, town, or county) (State): Jesterville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Cornelius Messick
ADDRESS: Bivalve, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 18 1956

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10807

## CERTIFICATE OF DEATH

10782 37

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILLARDS
c. LENGTH OF STAY IN 1b: 49 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WICOMICO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILLARDS
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RALPH Middle SMITH Last COOPER

4. DATE OF DEATH: Month OCT. Day 10, Year 1956

5. SEX: MALE

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 10, 1906

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRODUCE SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: TRUCK

11. BIRTHPLACE (State or foreign country): WILLARDS MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GORDON LEE COOPER

14. MOTHER'S MAIDEN NAME: IDA FLORENCE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MR. GORDON L. COOPER WILLARDS MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): unknown
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 15, 1956, to Oct. 10, 1956, that I last saw the deceased alive on Oct. 10, 1956, and that death occurred at 1045 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. R. Law M.D. ADDRESS (Street, city or town, state): Berlin DATE SIGNED: Oct-12-56

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/14/56

22c. NAME OF CEMETERY OR CREMATORY: WILLARDS

22d. LOCATION (City, town, or county) (State): WILLARDS MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Emma A. Burbage Berlin Md

24a. REC'D BY REGISTRAR DATE: OCT 15 1956

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

10783

# CERTIFICATE OF DEATH

Reg. Dist. No. 337

10778

**1. PLACE OF DEATH**

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

LENGTH OF STAY (in this place): 6 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

STREET ADDRESS (If rural give location): 304 Delaware Avenue

**3. NAME OF DECEASED** (Type or Print): (First) William (Middle) James (Last) Cottman

**4. DATE OF DEATH**: (Month) 10 (Day) 14 (Year) 19 56

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 24 HRS. Hours | IF UNDER 24 HRS. Min. |
|---|---|---|---|---|---|---|---|---|
| Male | A. A. | Married | 6-10-1906 | 50 yrs. | 4 | 4 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Waiter | Hotel | Salisbury, Wicomico Co., Md. | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel Cottman | Annie Christopher |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| No | No | 163-16-3014 | Mrs. Annie Cottman, 304 Del. Ave. Salisbury, Md. |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

502.1 IMMEDIATE CAUSE (A) Bronchiectasis — INTERVAL BETWEEN ONSET AND DEATH: 6 months, Undetermined

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Chronic Bronchitis

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 13 Sept., 19 56, to 14 Oct., 19 56, that I last saw the deceased alive on 14 Oct., 19 56, and that death occurred at 1:35 P.M., from the causes and on the date stated above.

SIGNATURE: H. Purnell, M.D. — ADDRESS (Street, city, town, state): 65 Medical Arts Bldg. Salisbury, Md. — DATE SIGNED: 16 Oct 56

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-17-56 | Green Acres Memorial Park | Salisbury, Wicomico Co. Md. |

| 24. RECEIVED BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| OCT 19 1956 | Mary W. Holloway | J. F. Stewart Funeral Home, Salisbury, Md. |

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10808

10784

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 70 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 400 State Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: 400 State Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara — Middle: Virginia — Last: Culver

4. DATE OF DEATH: Month: Oct. — Day: 8 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 31, 1886

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Wicomico County, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Burton LeCates

14. MOTHER'S MAIDEN NAME: Letetia Hearn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --------

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs James B. Hearn, Delmar, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis, peritoneal, liver — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): Carcinoma of Breast — 5 yrs

170 ×

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebal Thrombosis or metastases

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/1, 19 53, to death, 19 ____, that I last saw the deceased alive on 10/5, 19 56, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest M. Larmore M.D. — ADDRESS (Street, city or town, state): Delmar, Del — DATE SIGNED: 10/8/56

PHYSICIAN'S NAME (Type):

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial

22b. DATE THEREOF: 10-10-56

22c. NAME OF CEMETERY OR ~~CREMATORY~~: Mt. Olive

22d. LOCATION (City, town, or county) (State): Delmar, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Hearn Co - Delmar, Del — ADDRESS

24a. REC'D BY REGISTRAR DATE: 11 1956

24b. REGISTRAR'S SIGNATURE: Mary M. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10785

Item 9 FilmG206 11-7-56 et

# CERTIFICATE OF DEATH

10779

Reg. Dist. No. 332

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place) 12 Days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland COUNTY Somerset

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chance

STREET ADDRESS (If rural give location) 19 X 2

**3. NAME OF DECEASED** (Type or Print) (First) Greely (Middle) (Last) Dashiell

**4. DATE OF DEATH** (Month) October (Day) 27 (Year) 19 56

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | Approx. | 84 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired farmer | | Md | U.S. |

13. FATHER'S NAME: Edgar Washill

14. MOTHER'S MAIDEN NAME: Elizabeth Webster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-09-1747

17. INFORMANT & ADDRESS: Lucy Washiell Chance Md

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

610X IMMEDIATE CAUSE (A) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.

ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic C-V disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Benign prostatic hypertrophy.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-19-56 | Benign prostatic hypertrophy | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 3:3/4 P.M., from the causes and on the date stated above.

**SIGNATURE** William H. Fitch M.D. — **ADDRESS** (Street, city, town, state) Salisbury Md. — **DATE SIGNED** 10-29-56

| 23. BURIAL, CREMATION REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 10/29/56 | ~~Fruit Cove Cemetery~~ | Chance Md. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| 10/30/56 | Mary W. Hallowell Asst. Registrar | James F. Herriman | Princess Anne |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10809 10786

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Powellville
c. LENGTH OF STAY IN 1b: months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 12
d. STREET ADDRESS: 616 Smith St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sally; Middle: Truitt; Last: Davis

4. DATE OF DEATH: Month: 10— Day: 18— Year: 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 18, 1893

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical nurse

10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William G. Truitt

14. MOTHER'S MAIDEN NAME: Martha Niblett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elizabeth Calloway Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. p. m. Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-20-56

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: Oct. 21, 1956

22c. NAME OF CEMETERY OR CREMATORY: Truitt

22d. LOCATION (City, town, or county) (State): Willards, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter W. Haley ADDRESS: Pittsville, Md.

24a. REC'D BY REGISTRAR DATE: OCT 24 1956

24b. REGISTRAR'S SIGNATURE: Mary W. Calloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10787

# 10780 CERTIFICATE OF DEATH

Dr. Carrie Hearn M.D.-Salisbury, Md.

Reg. Dist. No. 33

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**1. PLACE OF DEATH**

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

STREET ADDRESS (If rural give location): Snow Hill Road

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| MARY | JOHNNA | DE FORGE | OCT. | 8th | 19 56 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | September 28, 1908 | 48 yrs. | 0 | 10 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Work at Home | None | Baltimore, Maryland | U S A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Walter Brewer | Lillian Loving |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|
| No | | Mr. Warren L. DeForge (Husband) Snow Hill Road - Salisbury, Maryland |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

531.2 IMMEDIATE CAUSE (A) Brain Abscess

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Abscessed teeth (Removed 2 weeks previously) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 10/3/56, 19..., to 10/8/56, 19..., that I last saw the deceased alive on 10/8/56, 19..., and that death occurred at 9:45 A.M., from the causes and on the date stated above.

SIGNATURE: Carrie L Hearn M.D. — ADDRESS (Street, city, town, state): 226 N. Division St Salisbury Md. — DATE SIGNED

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 11, 1956 | Wicomico Memorial Park | Salisbury, Maryland |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| OCT 9 1956 | Mary H Holloway | HOLLOWAY & COMPANY - SALISBURY, MARYLAND |

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10788

10781

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland COUNTY Worcester

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke

STREET ADDRESS (If rural give location) 434 Banks Street

**3. NAME OF DECEASED** (Type or Print) (First) (Middle) (Last) Douglas

**4. DATE OF DEATH** (Month) October (Day) 31 (Year) 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Newborn | October 30, 1956 | yrs. | | | 21 | 40 |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Doris Lucille Douglas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5 IMMEDIATE CAUSE (A) Respiratory Failure

ANTECEDENT CAUSE(S) DUE TO (B) Intraventricular Hemorrhage

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Atelectasis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Prematurity -

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

**22. I hereby certify** that I attended the deceased from 10/30, 1956, to 10/31, 1956, that I last saw the deceased alive on 10/30, 1956, and that death occurred at 5:00 P.M. from the causes and on the date stated above.

**SIGNATURE** William C. Morgan M.D. **ADDRESS** (Street, city, town, state) Salisbury, Md **DATE SIGNED** 11/3/56

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 11/5/56 | Peninsula General Hospital | Salisbury Md |

| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| DATE 11-6-56 | Mary A. Holloway | | |

2.082 22.1 XV 1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10789

Reg. Dist. No. 337

Items 11,10a, 13,14 FilmG206 11-7-56 et

10782

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

23x-2

| 3. NAME OF DECEASED (Type or print) | First | Middle | Last |
|---|---|---|---|
| | Hattie | | Gillette |

4. DATE OF DEATH: Month 10 — Day 25 — Year 19 56

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | | | 45 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at home | Achen, South Carolina | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Edema of the brain — INTERVAL BETWEEN ONSET AND DEATH: hours

443X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive cardio-vascular disease — years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Hour (o. m. / p. m.) | Month, Day, Year | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|---|---|---|---|---|---|---|
| | 19 | | | | | |

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Earl L. Royer, M.D. — 10-27-56

| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 27 1956 | County Cemetery | Snow Hill Md. |

| 23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS | 24a. REC'D BY REGISTRAR DATE | 24b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Norman T. Dennis, Snow Hill, Md. | NOV - 1 1956 | Mary N. Holloway |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S) 5M 9/55

1

10790

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10783

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury

LENGTH OF STAY (in this place): 1 Day

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland COUNTY Wicomico

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury

STREET ADDRESS (If rural give location): 512 Wicomico

**3. NAME OF DECEASED** (Type or Print): (First) (Middle) (Last): Gordy

**4. DATE OF DEATH** (Month) (Day) (Year): October 12 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | | October 11 1956 | yrs. | | 1 Day | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salisbury, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Jacqueline Layman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs Mary Layman

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

760.5 IMMEDIATE CAUSE (A): Intraventricular Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 Hours

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B):

(C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Prematurity

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

**22. I hereby certify** that I attended the deceased from 11 Oct, 19 56, to 12 Oct, 19 56, that I last saw the deceased alive on 12 Oct, 19 56, and that death occurred at 4:30 P.M, from the causes and on the date stated above.

SIGNATURE: [signature] M.D. — ADDRESS (Street, city, town, state): 976 N. Division St Salisbury — DATE SIGNED: 18 Oct 56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF: 10-18-56 | NAME OF CEMETERY OR CREMATORY: Peninsula General Hospital | LOCATION (City, town, or county) (State): Salisbury, Wicomico, Md

24. REC'D BY REGISTRAR DATE: 10-18-56 | REGISTRAR'S SIGNATURE: Mary W Holloway

25. FUNERAL DIRECTOR'S SIGNATURE: Peninsula General Hospital | ADDRESS: Salisbury, Md

2082192 XVJ

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10784 10791

# CERTIFICATE OF DEATH

Reg. Dist. No. 337

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place) 19 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland COUNTY Worcester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin

STREET ADDRESS (If rural give location) Route 3

**3. NAME OF DECEASED** (Type or Print) (First) Bertha (Middle) Cullin (Last) Haggerty

**4. DATE OF DEATH** (Month) October (Day) 28 (Year) 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | Oct. 12, 1887 | 69 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Philadelphia, Pa. | U.S.A. |

13. FATHER'S NAME Michel J. Cullin

14. MOTHER'S MAIDEN NAME Bertha Coleman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| No | No | None | Miss Margaret B. Haggerty Berlin Md |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X IMMEDIATE CAUSE (A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 week

ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary Fibrosis & Emphysema, Arteriosclerotic Heart Disease

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 10-8-1956 to 10-28-1956 that I last saw the deceased alive on Oct 28, 1956 and that death occurred at 8 P.M. from the causes and on the date stated above.

SIGNATURE Maud Gilmore M.D. — ADDRESS (Street, city, town, state) Salisbury Md. — DATE SIGNED Oct 28/1956

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 31, 1956 | Holy Sepulchre | Philadelphia Pa. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| OCT 31 1956 | Mary W. Holloway | Anna A. Burbage Berlin Md. |

RECEIVED
OCT 31 1956
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10785 **CERTIFICATE OF DEATH** Reg. Dist. No. 10792337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 2yr.9mo.8days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chester, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ unk ☐

3. NAME OF DECEASED (Type or print): First Arthur; Middle; Last Hazelton

4. DATE OF DEATH: Month Oct. Day 6 Year 1956

5. SEX: Male

6. COLOR OR RACE: colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 15, 1885

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~unk~~ Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Domestic ~~unk~~

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unk

14. MOTHER'S MAIDEN NAME: Josephine Dugger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unk (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unk

17. INFORMANT: Hospital Records — Address

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Syphilis heart disease — INTERVAL BETWEEN ONSET AND DEATH: unk
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

023X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CNS syphilis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 12, 1954, to Oct. 6, 1956 that I last saw the deceased alive on Oct. 6, 1956, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L.V. Maldve, M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 10/7/56

PHYSICIAN'S NAME (Type): L.V. Maldve, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/11/56
22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
22d. LOCATION (City, town, or county) (State): Chester Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: James B. Bloodwell — ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE: OCT 15 1956
24b. REGISTRAR'S SIGNATURE: Mary H. Williams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10819

## CERTIFICATE OF DEATH

10793

Reg. Dist. No. 33Y

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Railroad Ave.

d. STREET ADDRESS: Railroad Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NAPOLEON — Middle — Last HITCH

4. DATE OF DEATH: Month OCT. — Day 5 th — Year 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 17, 1881

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months 6 — Days 18

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Lumber Mill

11. BIRTHPLACE (State or foreign country): Sussex County Delaware

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Robert Hitch

14. MOTHER'S MAIDEN NAME: Catherine (Unk)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Fannie A. Hitch (Wife) — Address: Railroad Ave. Mardela, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 Days

331X

DUE TO (b): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 1st, 1956, to October 4th, 1956, that I last saw the deceased alive on October 4, 1956, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William Emrich M.D.

ADDRESS (Street, city or town, state): Hebron, Maryland

DATE SIGNED: October 6th 1956

PHYSICIAN'S NAME (Type): Dr. William Emrich

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 1956

22c. NAME OF CEMETERY OR CREMATORY: Mardela Cemetery

22d. LOCATION (City, town, or county) (State): Mardela Springs, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: OCT 9 1956

24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

10794

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10786 # CERTIFICATE OF DEATH

Reg. Dist. No. 337

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place) 4 Yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland COUNTY Worcester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke 23-42-2

STREET ADDRESS (If rural give location) P. O. Box 53

**3. NAME OF DECEASED** (Type or Print) (First) Elton (Middle) (Last) Hope

**4. DATE OF DEATH** (Month) 10 (Dey) 24 (Yaar) 19 56

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Deys | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Married | JULY 25-1906 | 50 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| SAWER | LUMBER MILL | VIRGINIA | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| WILLIAM H HOPE | OETA V. TULL |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| NO | — | 189-09-5659 | MRS GRACE C. HOPE (Pocomoke) |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6 hours

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Dey) (Yaar) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from ....., 19....., to 10/24, 1956, that I last saw the deceased alive on 10-24, 19 56, and that death occurred at .....M, from the causes and on the date stated above.

| SIGNATURE | M.D. | ADDRESS (Street, city, town, state) | DATE SIGNED |
|---|---|---|---|
| Wilbur A. Elder Jr | | Salisbury, Md. | 10-25-56 |

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/26/56 | Baptist Cemetery | Pocomoke Md. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| OCT 25 1956 | Mary H. Galloway | Henry K. Watson | Pocomoke Md. |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10787

10795

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 304 Poplar Hill Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK — Middle PALMER — Last HOPKINS

4. DATE OF DEATH: Month OCTOBER — Day 24th — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 16, 1883

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Poultryman

10b. KIND OF BUSINESS OR INDUSTRY: Chicking Work

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Alexander Hopkins

14. MOTHER'S MAIDEN NAME: Ida (Unk)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Lydia L. Hopkins (Wife) Address: 304 Poplar Hill Ave/ Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decomp — INTERVAL BETWEEN ONSET AND DEATH: 3-4 wks
DUE TO (b): Pulmonary Fibrosis — yrs
DUE TO (c):

525X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 19, 1956, to Oct 24, 1956, that I last saw the deceased alive on Oct 23 9:30a.m., 1956, and that death occurred at 9:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William D Gray M.D.
ADDRESS (Street, city or town, state): 334 Camden Ave. Salisbury, Maryland
DATE SIGNED: Oct. 25 1956

PHYSICIAN'S NAME (Type): Dr. William D. Gray M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 27, 1956
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: OCT 29 1956

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10811

## CERTIFICATE OF DEATH

10796

Reg. Dist. No. 33✓

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | |
|---|---|
| 1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tyaskin — c. LENGTH OF STAY IN 1b: Lifetime | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tyaskin |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or print) | First: Herman | Middle | Last: Horner | 4. DATE OF DEATH | Month: Oct. | Day: 7 | Year: 19 56 | |
| 5. SEX: Male | 6. COLOR OR RACE: White | 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH: 11-22-1886 | 9. AGE (In years last birthday): 69 yrs. | IF UNDER 1 YEAR: Months: 10 Days: 15 | IF UNDER 24 HRS.: Hours | Min. | |

| | | | |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer | 10b. KIND OF BUSINESS OR INDUSTRY: Own Farm | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY?: U.S. |
| 13. FATHER'S NAME: James E. Horner | | 14. MOTHER'S MAIDEN NAME: Luvicey Jane Hurley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---- | 16. SOCIAL SECURITY NO.: --- | 17. INFORMANT: Mrs. Reese Horner — Address: Tyaskin, Maryland | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
DUE TO (b): Cerebral Arteriosclerosis — 5 years.
DUE TO (c):

331✗
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

| | | | | |
|---|---|---|---|---|
| 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |

21. I certify that I attended the deceased from 4/4/49, 19____, to 10/17, 19 56, that I last saw the deceased alive on 10/17, 1956, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H Saunders M.D. — ADDRESS (Street, city or town, state): Nanticoke Md — DATE SIGNED: 10

PHYSICIAN'S NAME (Type): Richard H. Saunders — Nanticoke, Maryland — 10/10/56

| | | | | |
|---|---|---|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 22b. DATE THEREOF: 10/10/56 | 22c. NAME OF CEMETERY OR CREMATORY: Tyaskin Cem. | 22d. LOCATION (City, town, or county) (State): Tyaskin, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE: C. L. Messick — ADDRESS: Bivalve, Maryland | | 24a. REC'D BY REGISTRAR DATE: OCT 18 | 24b. REGISTRAR'S SIGNATURE: Mary L. Holloway | |

VS A15 (4)
15M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10788 **CERTIFICATE OF DEATH** 10797

Item 11, See: Birth Cert.

Reg. Dist. No. 332

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland COUNTY Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland

STREET ADDRESS (If rural give location) Box 256

**3. NAME OF DECEASED** (Type or Print) (First) (Middle) (Last) Jones

**4. DATE OF DEATH** (Month) (Day) (Year) October 20 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | | 10-18-56 | yrs. | | 2 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Salisbury | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Elaine Matilda Williams

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|
| | | |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

771.5 IMMEDIATE CAUSE (A) Intraventricular Hemorrhage

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Hemorrhage disease of the Newborn

DUE TO (C) Prematurity

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Meconium Ileus

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 10/18, 1956, to 10/20, 1956, that I last saw the deceased alive on 10/20, 1956, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

| SIGNATURE | M.D. | ADDRESS (Street, city, town, state) | DATE SIGNED |
|---|---|---|---|
| William C. Morgan | | Salisbury Md | 10/21/56 |

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | — | Peninsula General Hospital | Salisbury, Wicomico, Md. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| 10/24/56 | Mary W. Holloway | Mary W. Holloway |

2082-17 x V2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10812

## CERTIFICATE OF DEATH

Reg. Dist. No. 10798

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wetipquin
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wetipquin
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martenia — Middle: J. — Last: Jones

4. DATE OF DEATH: Month: Oct — Day: 31 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 7, 1886

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Salem Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm Charles Jenkins

14. MOTHER'S MAIDEN NAME: Margett Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-16-8195

17. INFORMANT: Thomas Jones — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Arteriosclerosis — 10 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 17 Sept., 19 47, to 31 October, 1956, that I last saw the deceased alive on 31 October, 1956, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H Saunders M.D. — ADDRESS (Street, city or town, state): Nanticoke Md — DATE SIGNED: 11/2/56

PHYSICIAN'S NAME (Type): Richard H. SAUNDERS — NANTICOKE Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 11-4-56 — 22c. NAME OF CEMETERY OR CREMATORY: Odd Fellows — 22d. LOCATION (City, town, or county) (State): Wetipquin Md

23. FUNERAL DIRECTOR'S SIGNATURE: Booker Wilson — ADDRESS:

24a. REC'D BY REGISTRAR DATE: 11-8-56 — 24b. REGISTRAR'S SIGNATURE: Mary W. Holloway per S.H.P.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10813

## CERTIFICATE OF DEATH

10800

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Parsonage St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
d. STREET ADDRESS: Parsonage St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE — Middle LEE — Last LIVELY

4. DATE OF DEATH: Month OCTOBER — Day 12th — Year 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 26, 1906

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at own Home

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Mt. Vernon, Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Ira T. Banks

14. MOTHER'S MAIDEN NAME: Flora Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Burton B. Lively (Husband) Address: Parsonage St. Fruitland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 15 Min
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 30, 1953, to Oct 12, 1956, that I last saw the deceased alive on Oct 12, 1956, and that death occurred at 7:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip A. Insley M.D. — ADDRESS (Street, city or town, state): 116 E. Main St (Office) — DATE SIGNED: Oct. 15 1956

PHYSICIAN'S NAME (Type): Dr. Philip A. Insley M.D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 15, 1956
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: OCT 18 1956
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10789

## CERTIFICATE OF DEATH

10802

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE ~~Md~~ b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Md
d. STREET ADDRESS 415 Booth St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Emma Middle V. Last Nichols

4. DATE OF DEATH Month Oct Day 4 Year 1956

5. SEX F

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH —

9. AGE (In years last birthday) 70 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W Dunby

14. MOTHER'S MAIDEN NAME Mary E. Barkley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 214-32-1472

17. INFORMANT Ida Walter Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 8 months
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 Feb, 19 56, to 4 Oct, 19 56, that I last saw the deceased alive on 4 Oct, 19 56, and that death occurred at 10:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE E. A. Purnell, M.D. ADDRESS (Street, city or town, state) 152 W Main St., Salisbury Md DATE SIGNED 6 Oct 56

PHYSICIAN'S NAME (Type) E. A. PURNELL, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Oct. 7, 1956

22c. NAME OF CEMETERY OR CREMATORY Green Acres

22d. LOCATION (City, town, or county) Salisbury (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Booker M Cusick ADDRESS

24a. REC'D BY REGISTRAR DATE 10-9-56

24b. REGISTRAR'S SIGNATURE Mabyll W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10790 **CERTIFICATE OF DEATH** Reg. Dist. No. 10803 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanticoke
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Grant — Last: Nutter

4. DATE OF DEATH: Month: October — Day: 23 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 4, 1956

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 19 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Grant Waters

14. MOTHER'S MAIDEN NAME: Constance Nutter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Grant Waters — Address: Nanticoke, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
763.0
DUE TO
(b): Acute Bronchiolitis — 1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congenital Heart Disease & Patent Ductus & Foramen Ovale

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/22, 1956, to 10/23, 1956, that I last saw the deceased alive on 10/22, 1956, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Morgan M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/25/56 October 25

22c. NAME OF CEMETERY OR CREMATORY: Nanticoke Cem.

22d. LOCATION (City, town, or county) (State): Nanticoke, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. H. Tyssen — ADDRESS: Bivalve, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 29 1956

24b. REGISTRAR'S SIGNATURE: Mary F. Holloway

2082201 x v 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10791

## CERTIFICATE OF DEATH

10804

Reg. Dist. No. 332

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
c. LENGTH OF STAY IN 1b: 52 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: Box 23
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clayton — Middle: A. — Last: Parker

4. DATE OF DEATH: Month: October — Day: 5 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/24/1869

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Parker

14. MOTHER'S MAIDEN NAME: Mary Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk.
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Hospital Records — Address

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Azotemia — INTERVAL BETWEEN ONSET AND DEATH: 1½ months

592X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Glomerulonephritis, chronic — ?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 13, 1956, to Oct. 5, 1956, that I last saw the deceased alive on Oct. 4, 1956, and that death occurred at 4:10A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Juerman. M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 10/5/56

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 8, 1956
22c. NAME OF CEMETERY OR CREMATORY: Glen Hill Cem
22d. LOCATION (City, town, or county) (State): Parsonsburg Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert M Leek — ADDRESS:

24a. REC'D BY REGISTRAR DATE: 10-10-56
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG206 11-2-56 et

10792

## CERTIFICATE OF DEATH

10805

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 425 West College Ave.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury,
d. STREET ADDRESS: 425 West College Ave,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eliza; Middle: ; Last: Polliard

4. DATE OF DEATH: Month: 10; Day: 20; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 14, 1865

9. AGE (In years last birthday): 91 89 yrs.
IF UNDER 1 YEAR: Months ; Days
IF UNDER 24 HRS.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): ~~Maryland~~ Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Patterson

14. MOTHER'S MAIDEN NAME: Mary Maise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. R.H.Polliard, Same
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage Sport — INTERVAL BETWEEN ONSET AND DEATH
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b): Arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. ; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 0, 19, to 0, 19, that I last saw the deceased alive on 0, 19, and that death occurred at about 7P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W B Smith M.D.
ADDRESS (Street, city or town, state): /
DATE SIGNED: 10/22/56

PHYSICIAN'S NAME (Type): Dr. William B. Smith, Medical Center, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/22/56
22c. NAME OF CEMETERY OR CREMATORY: Manokin Cemetery
22d. LOCATION (City, town, or county) (State): Princess Anne, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: 10-24-56
24b. REGISTRAR'S SIGNATURE: Mary W Holloway

Norman T. Baker

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10793

10806

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 33Y

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: — Last: Price

4. DATE OF DEATH: Month: 10 — Day: 9 — Year: 1956

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug 10 — 1911

9. AGE (In years last birthday): 45 1/12

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pocomoke City, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Finney

14. MOTHER'S MAIDEN NAME: Leiah Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-16-7181

17. INFORMANT: Viola Price Stevens — Address: 1069 Myrtle ave Baltimore 17 Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peripheral circulatory failure — INTERVAL BETWEEN ONSET AND DEATH: 4 hours.

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Multiple compound fractures — 4 hours
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.): Driving car involved in a two car collision.

20c. TIME OF INJURY: Hour: 2:45 P. M. — Month, Day, Year: 10-9- 1956

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): Newark (County): Worcester (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 10-9-56

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Oct. 13/56 — 22c. NAME OF CEMETERY OR CREMATORY: Baptist Cemetery — 22d. LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Wm E. Timmons, Snow Hill Md

24a. REC'D BY REGISTRAR DATE: OCT 15 1956

24b. REGISTRAR'S SIGNATURE: Mary H. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10814

10807

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 334

**1. PLACE OF DEATH**

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela Springs

LENGTH OF STAY (In this place): 70 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Main Street

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela Springs

STREET ADDRESS (If rural give location): Main Street

**3. NAME OF DECEASED** (Type or Print): (First) Edward (Middle) W. (Last) Russell

**4. DATE OF DEATH**: (Month) Oct. (Day) 16 (Year) 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Oct. 11, 1877 | 79 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Farmer | Farm | Wicomico County, Md. | USA |

13. FATHER'S NAME: Algeon Russell

14. MOTHER'S MAIDEN NAME: Arcadia Gravenor

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| No | ---------- | None | Frank Russell, Easton, Md. |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH/

542 X IMMEDIATE CAUSE (A) Pulmonary Edema (Acute) — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSE(S) DUE TO (B) Chronic Myocarditis — 6 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Chronic Nephritis — 7 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. **I hereby certify** that I attended the deceased from Aug. 31st 56 to Oct 16th 56, that I last saw the deceased alive on Oct 13th 56, and that death occurred at 10:15 A.M. from the causes and on the date stated above.

SIGNATURE: M. Spitznogle M.D. — ADDRESS (Street, city, town, state) — DATE SIGNED

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-18-56 | Mardela | Mardela Springs, Md. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| OCT 19 1956 | Mary N. Holloway | Charles W. Mowll Hughtown Md. |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9,13,14,16 FilmG206 11-5-56 et

10794

# CERTIFICATE OF DEATH

10808

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 431 Somerset Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS; Middle; Last SHILL

4. DATE OF DEATH: Month 10; Day 21; Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday): Approx. 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Resturant Owner

10b. KIND OF BUSINESS OR INDUSTRY: Food

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abraham Shill

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: 214-32-6784

17. INFORMANT: Mrs. Thomas Shill — Address: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Degenerative Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
422.2
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-1, 1956 to 10-21, 1956 that I last saw the deceased alive on 10-21, 1956, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W R Ellis, Jr. M.D.
ADDRESS (Street, city or town, state): Salisbury, Md.
DATE SIGNED: 10-22-56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/24/1956
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: George C. Shill II
ADDRESS: Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE: 10-24-56
24b. REGISTRAR'S SIGNATURE: Mary W Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10815 — 10809 — 335 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown.
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harvey — Middle: — Last: Smiley

4. DATE OF DEATH: Month: 10 — Day: 1 — Year: 19 56

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1876

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Esther Dunton, Sharptown, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arterio-sclerotic cardio-vascular disease — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-1-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/5/56
22c. NAME OF CEMETERY OR CREMATORY: Sharptown Cem.
22d. LOCATION (City, town, or county) (State): Sharptown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James Blakwell, Easton, Md.
24a. REC'D BY REGISTRAR DATE: OCT 15 1956
24b. REGISTRAR'S SIGNATURE: Mary C Owens

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10795 — 10819 — 338 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 37 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Martens
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Otis — Middle: EDWARD — Last: Smith

4. DATE OF DEATH: Month: 10 — Day: 29 — Year: 19 56

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 15, 1904

9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSERY EMPLOYEE
10b. KIND OF BUSINESS OR INDUSTRY: NURSERY
11. BIRTHPLACE (State or foreign country): WILLARD MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ERNEST SMITH
14. MOTHER'S MAIDEN NAME: ROSIE MORRIS.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: MR. ROLAND SMITH BERLIN, MD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Third degree burns of 95% body surface — INTERVAL BETWEEN ONSET AND DEATH: 37 hours

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Burned when kitchen caught fire.
20c. TIME OF INJURY: Hour: 7:30 a.m. p.m. — Month, Day, Year: 10-28-56
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): St. Martens — (County): Worcester — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-29-56

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/31/56
22c. NAME OF CEMETERY OR CREMATORY: New Hope
22d. LOCATION (City, town, or county): New Hope — (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Owen A. Burbage — ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR — DATE: OCT 31 1956
24b. REGISTRAR'S SIGNATURE: Mary H. Holloway Jr. M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10796

## CERTIFICATE OF DEATH

10811

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
d. STREET ADDRESS: Pine St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Stanley; Middle: M.; Last: Stanford

4. DATE OF DEATH: Month: Oct; Day: 25; Year: 1956

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 5, 1901

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Fruitland md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Burn Stanford.

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-10-8281

17. INFORMANT: Marian Stanford. Address: Fruitland md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2-4 hrs.
DUE TO
(b): Hypertensive Cardiovascular disease — sev. years
DUE TO
(c): Hypertension — years

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/16, 1956, to 10/25, 1956, that I last saw the deceased alive on 10/25, 1956, and that death occurred at 2 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Malby M.D.

ADDRESS (Street, city or town, state): Salisbury, Md.

DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 28-56

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cem

22d. LOCATION (City, town, or county): Fruitland (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Parker McMaster. ADDRESS: Salis. Md

24a. REC'D BY REGISTRAR DATE: 10/30/56

24b. REGISTRAR'S SIGNATURE: Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 0205 10-29-56 et

10797

# CERTIFICATE OF DEATH

Reg. Dist. No. 10812

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 mo.7 das.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 6, Maryland
d. STREET ADDRESS: 4308 Shamrock Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Marie — Middle — — Last Starkman

4. DATE OF DEATH: Month Oct. — Day 22 — Year 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 18, 1864
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Christian Pfeiffer
14. MOTHER'S MAIDEN NAME: Marie Pfeiffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address: Deer's Head Hos., Salisbury Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | 1. Acute myocardial insufficiency | 3 days |
| DUE TO | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | Arteriosclerotic cardiovascular disease | ? |
| DUE TO (c) | | |

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): --

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 14, 1956, to Oct. 22, 1956, that I last saw the deceased alive on Oct. 22, 1956, and that death occurred at 4:10A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve M.D.
ADDRESS (Street, city or town, state): Salisbury, Maryland
DATE SIGNED: 10/22/56
PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-25-56
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. H. Cook Inc.
ADDRESS: 1217 St. Paul St
24a. REC'D BY REGISTRAR DATE: Oct. 23 1956
24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10813

10816

# CERTIFICATE OF DEATH

336

Reg. Dist. No.

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**1. PLACE OF DEATH**

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar

LENGTH OF STAY (in this place): Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 417 East St.

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE: Maryland COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar

STREET ADDRESS (If rural give location): 417 East St.

**3. NAME OF DECEASED** (Type or Print): (First) ANNIE (Middle) M. (Last) Sturgis

**4. DATE OF DEATH**: (Month) Oct. (Day) 3 (Year) 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
|---|---|---|---|---|---|---|
| | | | | | Months / Days | Hours / Min. |
| Female. | White | Widowed | May 12, 1882 | 74 yrs. | / | / |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife. | Own home | Maryland | USA |

13. FATHER'S NAME: Josephus Elliott

14. MOTHER'S MAIDEN NAME: Addie J. Elliott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Helen Brewington, Delmar Del

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Second Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Cerebral Hemorrhage — 2 months

DUE TO (C) Arteria Sclerosis & Hypertension — 3 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

**22. I hereby certify** that I attended the deceased from Oct., 19 55, to Oct 3, 19 56, that I last saw the deceased alive on Oct 3, 19 56, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

**SIGNATURE** A. H. Lynch M.D. **ADDRESS** (Street, city, town, state) Delmar **DATE SIGNED** Oct

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/5/56 | Parsons Cemetery | Salisbury Md. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| OCT 8 1956 | Harry Hudson | N. E. Dickerson | Laurel Del. |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10814

10798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 418 E. Isabella St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LLOYD Middle JAMES Last SULLIVAN

4. DATE OF DEATH: Month OCTOBER Day 21st Year 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 29, 1885

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months 0 Days 22
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter -Self Employed

10b. KIND OF BUSINESS OR INDUSTRY: -House Painter

11. BIRTHPLACE (State or foreign country): R.D.# Delmar, Delaware

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Isaac Sullivan

14. MOTHER'S MAIDEN NAME: Ellen Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Lena Sullivan(Wife) Address: 418 E. Isabella St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.

EXAMINER'S NAME (Type): Dr. Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: October 23 1956

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 24, 1956

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE: OCT 24 1956

24b. REGISTRAR'S SIGNATURE: Mary N. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10815

10817

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

**1. PLACE OF DEATH**

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Allen

LENGTH OF STAY (in this place): All life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: At home - Allen, Md.

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE: Maryland — COUNTY: Wicomico

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural

STREET ADDRESS (If rural give location): Eden, Md. Rt. # 2 Box 50

**3. NAME OF DECEASED** (Type or Print): (First) Letha (Middle) Otina (Last) Thompson

**4. DATE OF DEATH**: (Month) 10 — (Day) 23 — (Year) 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | A.A. | Baby | 6-24-56 | yrs. | 3 | 29 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Baby | Baby | P. G. Hospital, Salisbury, Md. | Baby |

13. FATHER'S NAME: Levi C. Thompson

14. MOTHER'S MAIDEN NAME: Josephine E. Leatherbury

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Baby (If Yes, give wer or dates of service)

16. SOCIAL SECURITY NO. ~~Baby~~

17. INFORMANT & ADDRESS: Eden, Md. Rt. #2 Box 50 — Mrs. Josephine E. Thompson, Allen, Md.

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

493X IMMEDIATE CAUSE (A) Pneumonia

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Yaer) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 10-22-56, to 10-22-56, that I last saw the deceased alive on 10-22-56, and that death occurred at 2 A.M, from the causes and on the date stated above.

| SIGNATURE | ADDRESS (Street, city, town, state) | DATE SIGNED |
|---|---|---|
| Wm B Smith M.D. | Med. Center, Sby, Md. | 10-24-56 |

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-24-56 | Allen Cemetery | Allen, Wicomico Co., Md. |

| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| DATE OCT 29 1956 | Mary F. Holloway | J. F. Stewart Funeral Home, Salisbury, Md. |

21 22 23 24 25 4

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Itme 8 FilmG205 10-29-56 et

10799

10816

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisburg
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Parsons Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John; Middle: Warren; Last: Turner

4. DATE OF DEATH: Month: Oct.; Day: 19; Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/3/1885

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months: 2; Days: 16
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fisherman

10b. KIND OF BUSINESS OR INDUSTRY: Commercial

11. BIRTHPLACE (State or foreign country): Nanticoke, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Warren D. Turner

14. MOTHER'S MAIDEN NAME: Tressa Robertson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --------

16. SOCIAL SECURITY NO.: 220-09-1690

17. INFORMANT: Address: Mrs. Mae Turner, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days
420.1
DUE TO (b): Coronary Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on October 19, 1956, and that death occurred at 12:53 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C Hill Jr. M.D.
ADDRESS (Street, city or town, state): 224 N. Division St., Salisbury, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Thomas C. Hill Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/21/56
22c. NAME OF CEMETERY OR CREMATORY: Turner's Cem.
22d. LOCATION (City, town, or county) (State): Nanticoke, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. T. Messick
ADDRESS: Bivalve, Maryland

24a. REC'D BY REGISTRAR DATE: 10/26/56
24b. REGISTRAR'S SIGNATURE: Mary W Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10800

10817

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 322

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place) 16 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Md. COUNTY Somerset

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deal Island

STREET ADDRESS (If rural give location) None

**3. NAME OF DECEASED** (Type or Print) (First) Adolphus (Middle) (Last) Walters

**4. DATE OF DEATH** (Month) October (Day) 20 (Year) 1956

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | widowed | Aug 6-1887 | 69 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Retired Waterman | Deal Island Md. | U.S.A. |

**13. FATHER'S NAME** HAMILTON WALTERS

**14. MOTHER'S MAIDEN NAME** MELISSA WEBSTER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|
| No | None | Daughter Mrs Flossie Blocksworth Salisbury Md |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from 10/4, 1956, to 10/20/, 1956, that I last saw the deceased alive on 10-20, 1956, and that death occurred at 6:15 P.M. from the causes and on the date stated above.

| SIGNATURE | M.D. | ADDRESS (Street, city, town, state) | DATE SIGNED |
|---|---|---|---|
| Willem R. Ebert | | Salisbury, Md. | 10-22-56 |

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 23-1956 | St Johns Cemetery | Deal Island Md |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| 10/25/56 | Lola T. Mitchell Mary H. Holloway | L Dykstra | Deal Island Md |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10801 — Reg. Dist. No. 10818 337

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shad Point
d. STREET ADDRESS: R.D.# 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle ERNEST — Last WILLIAMS

4. DATE OF DEATH: Month OCT. — Day 16 th — Year 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: June 10, 1896

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months 4, Days 6 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter Work - Construction - Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Shad Point, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Fredrick A. Williams

14. MOTHER'S MAIDEN NAME: Ida M. Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Iva M. Williams (Wife) Address: R.D.# 1 Salisbury, Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenteric Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 23 hrs.
DUE TO (b): Arteriosclerosis — yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ], and find that death resulted from: Natural causes [✓], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Dr. Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: October 18 1956

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 20, 1956
22c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery - Shad Point - R.D.# Salisbury, Md.
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: OCT 19 1956
24b. REGISTRAR'S SIGNATURE: Mary W. Holloway D

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10819

## CERTIFICATE OF DEATH

10802 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b II weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Franklin Middle A. Last Willing
4. DATE OF DEATH Month Oct. Day 26, Year 19 56
5. SEX male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Feb. 28, 1859
9. AGE (In years last birthday) 97 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired waterman
10b. KIND OF BUSINESS OR INDUSTRY seafood
11. BIRTHPLACE (State or foreign country) Bivalve, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Willing
14. MOTHER'S MAIDEN NAME Susan Larmore
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. no
17. INFORMANT Address Mrs Mark White Princess Anne, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
422.2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/22, 19 56, to 10/26, 19 56, that I last saw the deceased alive on 10/26, 19 56, and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Earl M Bradley M.D. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 10/27/56
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) burial
22b. DATE THEREOF 11-28-1956
22c. NAME OF CEMETERY OR CREMATORY Bivalve Cemetery
22d. LOCATION (City, town, or county) (State) Bivalve, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Leon R. Wilson ADDRESS Princess Anne, Maryland
24a. REC'D BY REGISTRAR DATE 10/30/56
24b. REGISTRAR'S SIGNATURE Mary W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10820

10803 **CERTIFICATE OF DEATH**

Reg. Dist. No. 332

**1. PLACE OF DEATH**

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY

LENGTH OF STAY (In this place) 1 DAY

HOSPITAL OR INSTITUTION OR STREET ADDRESS PENINSULA GENERAL Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Md — COUNTY WORCESTER

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN

STREET ADDRESS (If rural give location) R.F.D. TAYLORVILLE

**3. NAME OF DECEASED** (Type or Print) (First) ALICE (Middle) GERTRUDE (Last) WYATT

**4. DATE OF DEATH** (Month) October (Day) 24 (Year) 1956.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| F | W. | WIDOW | MAR. 10, 1872 | 84 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WIFE | OWN HOME | SNOW HILL, MD. | U.S.A. |

13. FATHER'S NAME JAMES TAYLOR.

14. MOTHER'S MAIDEN NAME SARAH WILLIAMS.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| No | No | No | Mr James R. Wyatt, Berlin Md |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH Centenarian

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED White at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on 10-24, 19 56, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

| SIGNATURE | M.D. ADDRESS (Street, city, town, state) | DATE SIGNED |
|---|---|---|
| William R. Collins Jr | Salisbury, Md | 10-24-56 |

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10/28/56 | TAYLORVILLE | BERLIN (RFD) MD |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| 10/26/56 | Mary W. Holloway | Anna A. Burbage | Berlin Md |